

INTERIM REPORT

of the

FACT-FINDING COMMITTEE

Appointed by Commissioner John O. Boone

August 16, 1972

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Presented by:

John A. Gavin (Chairman)
Henry J. Mascarello (Vice-Chairman)
John M. Keeley
Fred Butterworth
Francis J. Carney



Commissioner John O. Boone Massachusetts Department of Correction 100 Cambridge Street Boston, MA

Dear Commissioner Boone:

In answer to your letter of August 3, 1972 requesting me to act as Chairman of a committee to investigate the tragic deaths which occurred on July 31, 1972 at Norfolk, I am submitting the attached interim report.

The committee, composed of Mr. Henry Mascarello, Major John Keeley, Mr. Frank Carney, Mr. Fred Butterworth and myself, brought to their work a varied viewpoint but a concern to find as many facts as possible and to call the shots as they saw them from the testimony garnered.

The committee started interviewing on Friday morning at Norfolk, interviewed all day Saturday until early evening, resumed on Monday, August 7th and met every day all day until today to wrap up this report. In addition the Chairman assigned work to be done by each committee member at home to expedite the information being gathered.

In the course of the hearing of personnel and others, we allowed considerable latitude to the persons testifying and many periphery items were heard that have an important bearing on the smooth running of MCI, Norfolk and the Department of Correction, as well as the other institutions in the Department. To give you the benefit of this added information, it will require a more detailed report at a later date which we hope to complete within a six-week period.

It should be noted that all parties concerned, Norfolk administration, upper eschelon persons, Union representatives, officers, civilians, inmates and inmate visitors who appeared before the committee were concerned and anxious to assist in any way possible to prevent a recurrence of this tragedy. We have not attempted to place the blame on any one segment of the Department or its institution but we have attempted to place the facts as we heard them before you for your consideration. We trust you will accept this report in the spirit it was written and our hope is that its contents will be of help to you and the Department and its institutions.

Respectfully submitted,

John A. Gavin Chairman Digitized by the Internet Archive in 2014

INTRODUCTION

The turmoil and unrest in corrections throughout the nation over the past year is evident even to the casual observer. A tense, and occasionally explosive, atmosphere has tended to pervade correctional institutions across the country in the wake of the tragic events that took place at Attica, San Quentin, Rahway, etc. In Massachusetts this tense correctional climate has been reflected in serious disturbances, inmate work stoppages, general lockups, officer sick-outs, etc.

During the nation-wide period of upheaval, the focus of the mass media, the courts, and the public in general has been on the correctional field. With the public spotlight on corrections during this emotionally-charged period, there has been a tendency on the part of people with various points of view to oversimplify what are very complex correctional issues. At this time, rhetoric has seemed to replace reason, and polarization has seemed to be the predominant process operating among people concerned with corrections.

The committee feels that the turmoil and unrest, which seem to exist in virtually every correctional jurisdiction across the country, ought to be acknowledged at the outset. It is within the context of the currently tense correctional climate that the events surrounding the tragic incident of July 31, 1972, at MCI, Norfolk should be viewed.

In addition to acknowledging the tense atmosphere in corrections today, the committee feels that it is important to mention something about the history of Norfolk as background to this report.

MCI, Norfolk is a medium security, male institution which was officially opened in 1931. In its physical environment it is more suggestive of a college campus than of the traditional sterotype of a prison. Residents live in dormitories which are built on the perimeter of a large, open quadrangle. The original goal of this type of architecture was to create, as much as possible, an atmosphere of community life. Family visits have always been a vital part of the Norfolk program, and outside volunteers have traditionally been encouraged to participate in correctional programs at Norfolk. This kind of contact with the outside has been considered very helpful in preparing a man to return to the community.

The Department of Correction has always tried to be selective in choosing the inmate population of Norfolk. Men are not committed there directly from the courts, but are transferred to Norfolk primarily from Walpole after going through a screening, or classification, process. The goal of the Department of Correction has been to transfer to Norfolk the more hopeful inmates, in terms of rehabilitation potential, as well as the better behaved inmates in terms of institutional adjustment. It is important to note that one of the above characteristics does not necessarily imply the other.

The committee would also like to make clear at the outset its support for the correctional reforms of recent and current administrations. It would be





compounding tragedy to reverse in any degree the efforts to improve correctional programs in this state. Genuine long-term security for the public, correctional personnel, and inmates will be achieved only when it is acknowledged that the correctional system cannot stand still in the face of rapid social change around it.

At the same time, the committee recognizes that effective change in corrections must be developed in a setting of orderliness and security. Modern correctional goals cannot be attained without careful planning, restraint, and discipline. These factors must be considered essential ingredients in the enterprise of correctional reform.

The committee felt that these brief comments on the tense atmosphere in corrections today, on the history of Norfolk, on its stance regarding correctional reform, and on its recognition of the need for a thoughtful and rational approach to change in corrections would be important as background for this report. Some of these comments may be helpful in developing some perspective from which the tragic events of July 31 can be viewed. Attention will now be directed to the report itself.

Purpose of the Report

On August 3, 1972, Commissioner John O. Boone appointed a five-member fact-finding committee consisting of the following individuals:

- John A. Gavin (Chairman), Correctional Consultant*and Retired Commissioner of the Massachusetts Department of Correction
- Henry J. Mascarello (Vice-Chairman), Executive Director of the Massachusetts Correctional Association
- Fred Butterworth, Chief Security Officer, Massachusetts
 Department of Correction
- Francis J. Carney, Acting Director of Research and Planning,
 Massachusetts Department of Correction
- John M. Keeley, Major, Massachusetts State Police

The charge to this committee by Commissioner Boone was twofold:

- 1) To investigate the incidents and circumstances leading up to the tragic deaths at MCI, Norfolk.
- Review security operations surrounding the administration of visiting policy, including access of family and friends, delivery and business visits, volunteers, etc. at MCI, Walpole, MCI, Norfolk, and MCI, Concord.

^{*} Mr. Gavin is a Correctional Consultant for Socio-Technical Systems Associates.



In the course of its work, numerous significant issues emerged which the committee felt had important implications for improvements in the Department of Correction. It became clear that it would be impossible to deal adequately with many of these issues because of the recognized importance of producing a timely report on the details of the events of July 31.

The committee decided, therefore, to present an Interim Report as soon as possible. This Interim Report will focus on the events surrounding the tragic incident of July 31. The goal will be to document the facts surrounding the incident as accurately as possible, to present a reasonable interpretation of the facts, and to make recommendations for the future. At a later date --- hopefully, in about six weeks --- the committee will present a more detailed report dealing with some of the more general issues and recommendations that have emerged from our work.

Method of Information Collected

The committee conducted interviews with 35 individuals, including the following:

- 4 members of the Norfolk administration (Superintendent, Deputy Superintendent, Director of Treatment, Steward)
- 11 Correction Officers (including a Union Official)
- 13 residents
- 3 visitors who were in the visiting room on the morning of July 31
- 3 administrators from the Central Office of the Department (the Acting Commissioner on July 31, a Deputy Commissioner, and the Executive Assistant to the Commissioner)

In addition, all pertinent written material directly or indirectly related to the incident of July 31 or to institutional security was assembled and reviewed by the committee. This included policy statements, rules and regulations, procedures, correspondence, reports, memos, etc. Also the case folder of Walter Elliott was reviewed by the committee.

It should be mentioned that one important source for our fact-finding enterprise was necessarily unavailable to us at this time. That is, because there is an investigation under way which could possibly result in court prosecutions, the State Police detectives conducting the investigation into the incident had not completed their inquiry and were, therefore, not able to discuss the case with us.



PRESENTATION OF FACTS SURROUNDING THE JULY 31 TRAGEDY

I. Events Leading Up To July 31

A. Intelligence on Escape Plan

The State Police, in cooperation with the staff at MCI, Norfolk, have been conducting an investigation into certain problems within the institution. One result of this investigation was that five Norfolk inmates were transferred to Walpole on July 26 and 27.

In the course of this investigation information was received, sometime in mid-July, that there was an escape attempt being planned by five inmates at MCI, Norfolk. One of the five inmates in the alleged escape plot was Walter Elliott.

On Wednesday, July 26, the information on the alleged escape attempt was corroborated by another independent source. This information led Superintendent Bohlinger to believe that an escape attempt would be made over the wall and that weapons may be secluded just outside the wall. At that point Superintendent Bohlinger, Deputy Superintendent Ristaino, and Detective Miller of the State Police made a search of the area outside the wall where the alleged escape was to have taken place. Their search did not uncover any weapons.

B. Communication with Commissioner's Office on Transfers of Inmates

At this point, Superintendent Bohlinger felt that he had reliable information on a forthcoming escape attempt. On Thursday morning, July 27, Superintendent Bohlinger called the Commissioner's office and conveyed this information to Mr. William Farmar, Executive Assistant to the Commissioner, and asked that the five inmates be transferred from Norfolk to Walpole. (It should be noted that only the Commissioner or the Acting Commissioner has the power to transfer an inmate from one institution to another.) Mr. Farmar indicated that he would convey the information and the request for transfer to Miss Patricia Iorio, the Acting Commissioner in the absence of Commissioner Boone who had been on vacation during the week of July 23. Miss Iorio and Mr. Farmar decided that the matter should be discussed with Mr. Joseph Higgins, Deputy Commissioner for Institutional Services who was at Walpole at the time. After discussing the matter with Mr. Higgins, it was decided that it would not be advisable to transfer these five inmates to Walpole at this time. A main factor underlying this decision was the fact that the situation was extremely tense at Walpole at this time. Four chronic troublemakers had just been transferred from Walpole to the Federal Prison System and there was some unrest in the wake of this transfer. Also, five other troublesome inmates had just been transferred from Norfolk to Walpole on Wednesday and Thursday (July 26 and 27). Therefore, it was decided that the atmosphere was too tense at Walpole at that time to effect the transfer of five more behavioral problems from Norfolk



to Walpole. It was suggested, instead, that a shakedown be conducted, that the wires on the wall be checked to make sure the electricity was running through them, and that the staff keep a watchful eye on those in the alleged escape plan.

On Friday morning, July 28, Superintendent Bohlinger called Mr. Farmar and was informed of the decision that the five inmates not be transferred at this time. (It should be noted that the tension at Walpole was further illustrated by the fact that an inmate there was murdered on Friday, July 28.)

On Friday, July 28, Superintendent Bohlinger wrote a letter to Commissioner Boone requesting the removal of Walter Elliott and five other inmates from Norfolk to a maximum security institution based on his information that they were planning an escape. This letter arrived in the Commissioner's office on Monday, July 31. However, it was not opened until after word had been received from Norfolk concerning the unfolding tragedy there. This word reached the Commissioner's office at approximately 10:00 AM.

C. Issue of Institutional Lockup

When the request for transfer was denied, Superintendent Bohlinger faced the question of whether or not to lock up the five or six inmates in the institution's Receiving Building --- the only relatively secure unit in the institution. He decided not to lock these men up at this time for a number of reasons. First, because these men had not committed any infraction of the institution rules, it was not possible to lock them up under existing disciplinary policies and procedures. It was Superintendent Bohlinger's judgement that to lock them up with no infraction may have precipitated a dangerous situation in the institution because of the reaction of the other inmates and because of the unrest which prevailed at Norfolk. Further, his information was that they would go over the wall and he felt that they could be watched closely enough to prevent this from happening. Also, the Receiving Building is located such that it juts out into the yard of the institution and it is possible for men locked in the Receiving Building to incite other inmates from their cells. Finally, Superintendent Bohlinger noted that the last mass escape from Norfolk originated from the Receiving Building.

D. Chronology of the Purchase and Installation of the Metal Detector

The first request for a walk-through metal detector was included in the Supplementary Budget dated October 12, 1971. The metal detector had the number one priority among equipment requests. This request was approved by the Legislature and the official purchase order (No. P-063516) was made on April 27, 1972. The first parts of the metal detector arrived at the institution in mid-July. The last parts, which included the meters --- without which the metal detector is not workable --- arrived at the institution on August 4. The delay in delivery is not unusual and can be



explained, in part, by the demand for metal detectors by correctional institutions in the wake of Attica and by airlines in the wake of the recent hijackings. The metal detector was installed on August 7.

There had been in the institution for a number of years a semi-portable metal detector in the form of a "paddle frisker". It is the committee's impression that many employees did not know of the existence of this device in the institution. Following the tragedy of July 31, this "paddle frisker" was used as a metal detecting device on all visitors coming into and going out of Norfolk until the new walk-through metal detector was installed. Apparently, it had never been used for this purpose prior to August 1.

II. Chronology of the Events of July 31

A. Events in the Gate House

Mrs. Katherine Elliott was dropped off by a taxi at the Gate House of MCI, Norfolk at approximately 9:15 AM. Despite the fact that the day was unusually hot and humid, she was wearing a long "granny" skirt, a blouse, and a three-quarter length yellow raincoat. She was not carrying a pocketbook or a purse on this occasion. On her many previous visits to her husband Walter Elliott, she characteristically did carry a pocketbook or purse which she checked at the gatehouse as all female visitors do according to institutional policy. Her mode of dress was noted by gatehouse officers, but it was not considered particularly unusual inasmuch as it was consistent with clothing that is worn "on the street". (This is the standard by which the appropriateness of visitors' clothing is measured according to institutional policy.)

Mrs. Elliott's visitor's pass was processed and approved by Officer Harry Morriss in routine fashion and she was admitted into the institution. Reports of gatehouse personnel indicate that there was nothing unusual or suspicious about her behavior in the gatehouse. Mrs. Elliott went from the gatehouse directly to the Administration Building where she was admitted into the visiting room and sat down on a bench to await the arrival of her husband.

B. Events in the Visiting Room

On the morning of July 31, Walter Elliott left his living unit (6-2) at the usual time to report to his work assignment as an institutional barber in the School Building. He was given a pass by the Officer-In-Charge (OIC) at approximately 9:25 AM to go to the visiting room to meet with his visitor.

When Mr. Elliott arrived at the main gate of the Administration Building, he was wearing a white shirt and black, tight-fitting trousers. At the main gate of the Administration Building, he was given a routine



shakedown by Officer Malcolm Harkins. This shakedown was observed by Officer Stephen Northrop. The committee feels that Mr. Elliott's clothing is significant. It is the committee's feeling that it would have been virtually impossible for Mr. Elliott to have concealed two weapons on his person, given the tightness of his trousers and the frisk administered by Officer Harkins.

After the shakedown Mr. Elliott was admitted through the main gate of the Administration Building by Officer Harkins and proceeded to the visiting room. He presented his pass to Officer Northrop at the entrance of the visiting room and was admitted into the visiting room where he sat down on a bench beside his wife.

Witnesses in the visiting room reported that, within about two or three minutes after he sat down beside his wife, Mr. Elliott rose and approached the officer's desk in the visiting room with his hands behind his back and a pistol in each hand. At the desk, Officer James Souza was sitting down assisting Officer Paul Agoue, an officer assigned to the nearby institution hospital, in the writing of a disciplinary report. When he was within about 20 feet of the officer's desk, Mr. Elliott pointed the two guns at Officers Souza, Agoue, and Northrop and told them to come over to the middle of the visiting room and lie down on the floor. Officers Northrop and Agoue followed Mr. Elliott's instructions and went to the middle of the visiting room. Officer Souza did not. Again, Mr. Elliott ordered Officer Souza to go to the middle of the visiting room and lie down on the floor. Officer Northrop and an inmate who was in the visiting room urged Officer Souza to follow Mr. Elliott's instructions. When Officer Souza didn't move, Mr. Elliott shot him in the shoulder while he was still sitting at the officer's desk, and he fell to the floor from his chair behind the desk.

At this point, Officer Agoue made a break for the back door of the visiting room. He was able to get out the back door of the visiting room, run across the corridor to the Superintendent's office where he informed the Superintendent and the Deputy Superintendent of what happened. Superintendent Bohlinger and Deputy Superintendent Ristaino immediately notified the State Police, the Commissioner's office, and began the process of securing the institution.

Meanwhile, just as Mr. Elliott shot Officer Souza, Supervising Officer Joseph McHugh approached the entrance of the visiting room. He heard a shot and saw Officer Souza fall to the floor. Then, Mr. Elliott, with Mrs. Elliott standing at his side, pointed a gun at Officer McHugh. Since Officer McHugh was not yet inside the visiting room he was able to duck out of Mr. Elliott's line of vision, moving toward the main gate. At the main gate, he alerted Officer Harkins to the situation and both men ran through the main gate up the path in the general direction of the Community Service Department (CSD)



Building. On the way, Officer McHugh alerted Mr. Baranowski, an institution shop instructor, who was supervising an inmate work crew that was beginning construction of a new visiting room. Officer McHugh continued on to the CSD Building where he phoned the gatehouse, alerting them of the situation. Officer Harkins and Mr. Baranowski headed toward the three units; Officer Harkins to unit 3-2 and Mr. Baranowski to unit 3-1. All the inmates on the work crew scattered to the safety of nearby buildings.

Meanwhile, Mr. Elliott left the visiting room to pursue Officers McHugh and Harkins. On his way out the visiting room door, Mr. Elliott encountered Officer David Mackey, a hospital officer who had just come from the hospital to pick up the mail. Mr. Elliott ordered Officer Mackey to go into the visiting room and lie down on the floor. Mr. Elliott proceeded to the main gate where he ordered Officers McHugh and Harkins back into the Administration Building. When both continued to run in the opposite direction, he fired one shot at Officer Harkins, missing him.

When Officer Mackey entered the visting room, he saw Officer Souza lying wounded on the floor. He went to Officer Souza's assistance and found him still alive and moaning softly. While Officer Mackey was bent over Officer Souza rendering him assistance, Mr. Elliott returned to the visiting room. He is reported to have shouted to Officer Mackey to get away from Officer Souza, and at the same time, to have fired a shot at Mr. Mackey which struck him in the back of the head. He then leaned over the officer's desk and fired another shot into the body of Officer Souza.

Then, Mr. Elliott, with Mrs. Elliott by his side, began to move from the officer's desk back into the middle of the visiting room. At that point, Officer Northrop was still in the visiting room. He was about to make an attempt to leave the visiting room when he was warned by an inmate in the visiting room that Mr. Elliott was returning to the visiting room. He was able to get underneath a bench before Mr. Elliott came back into the visiting room. Then, another inmate and his visitor slid down the bench so that their legs were over Officer Northrop and helped to hide him from the view of Mr. Elliott. It is the opinion of the committee that the actions of these inmates and this visitor probably saved Officer Northrop from being shot by Mr. Elliott.

When Mr. Elliott came from the officer's desk toward the middle of the visiting room, it was reported by several witnesses that he stopped, looked around the room, and made an apology to those present for "making such a fuss." It was further reported by several witnesses that Mrs. Elliott was constantly at the side of Mr. Elliott during the entire episode inside and outside the visiting room, and that both were extremely calm and cool at all times. No one reported to the committee any evidence of panic or any evidence of pre-arranged plans having gone awry in the behavior of Mr. or Mrs. Elliott.



After making the apology, Mr. and Mrs. Elliott left the visiting room and proceeded directly to the main gate of the Administration Building leading back into the institution. At no time did they make any attempt to move toward the front gate of the Administration Building which leads to the outside of the institution. Mr. and Mrs. Elliott left the Administration Building through the main gate heading back into the institution, walked along the path toward the CSD Building, and turned right in the direction of units 3-1 and 3-2.

After Mr. and Mrs. Elliott left the Administration Building, Dr. Della Pena who was in the nearby institution hospital administered to Officers Mackey and Souza.

C. Events in units 3-2 and 3-1

After Officer Harkins left the Administration Building, he went into unit 3-2, along with Officer Philip Concaison. Officer Harkins called the gatehouse to alert them of the situation. He then attempted to call the Officer -in-Charge (OIC) but could not get through to him. Therefore, Officer Concaison ran from unit 3-2 to the OIC (School Building) to inform him of the situation. When Officer Concaison was leaving unit 3-2, he saw Mr. Baranowski going into unit 3-1. Officer Harkins went upstairs in unit 3-2 where he stayed until he saw Mrs. Elliott go past unit 3-2 toward the seven units.

Mr. Baranowski, along with Officers Ray and Marshall, were in unit 3-1 when Mr. and Mrs. Elliott began to walk down the path on the side of the quadrangle where the three and the seven units are located.

It was reported that Mr. and Mrs. Elliott initially walked past unit 3-1 and went into unit 3-2. Not finding any staff in unit 3-2, they came back to unit 3-1. Mr. Elliott entered unit 3-1; Mrs. Elliott remained on the steps outside. Mr. Baranowski was reportedly hiding in the kitchen when Mr. Elliott entered unit 3-1. Mr. Elliott came into unit 3-1 and went to cellar door where he stood momentarily looking down the cellar stairs. At that point, Mr. Baranowski made a move from the kitchen either toward the door of unit 3-1 or toward Mr. Elliott. Mr. Elliott fired at least two shots into Mr. Baranowski and he fell to the floor very close to the front door of unit 3-1.

Mr. Eliott then asked an inmate in 3-1 where the other officers were. The inmate replied that he didn't think there were any officers in the building although he knew that Officers Ray and Marshall were hiding nearby. The committee feels that this statement by the inmate may well have saved these officers from possible harm.

Then, Mr. Elliott joined Mrs. Elliott on the steps outside unit 3-1. At this point, he was reportedly heard to say to Mrs. Elliott, "Whatever happens we'll meet in the next world. Don't worry, hon."



Mr. and Mrs. Elliott then proceeded along the walk toward unit 7-3. Several witnesses reported that they walked along very slowly and calmly as though they were out for a stroll. It was reported that when they reached the area on the walk approximately between units 3-3 and 7-1, they stopped and kissed each other. It was also reported that when they were outside unit 7-2, Mr. Elliott casually fired a shot into unit 7-2. They then proceeded into unit 7-3 where they prepared to barricade themselves in.

The committee feels that the choice of unit 7-3 was significant because it was a closed unit. That is, unlike many other units, the individual rooms in unit 7-3 had doors that could be closed. In Mr. Elliott's own unit (6-2), for example, there were no doors on the individual rooms.

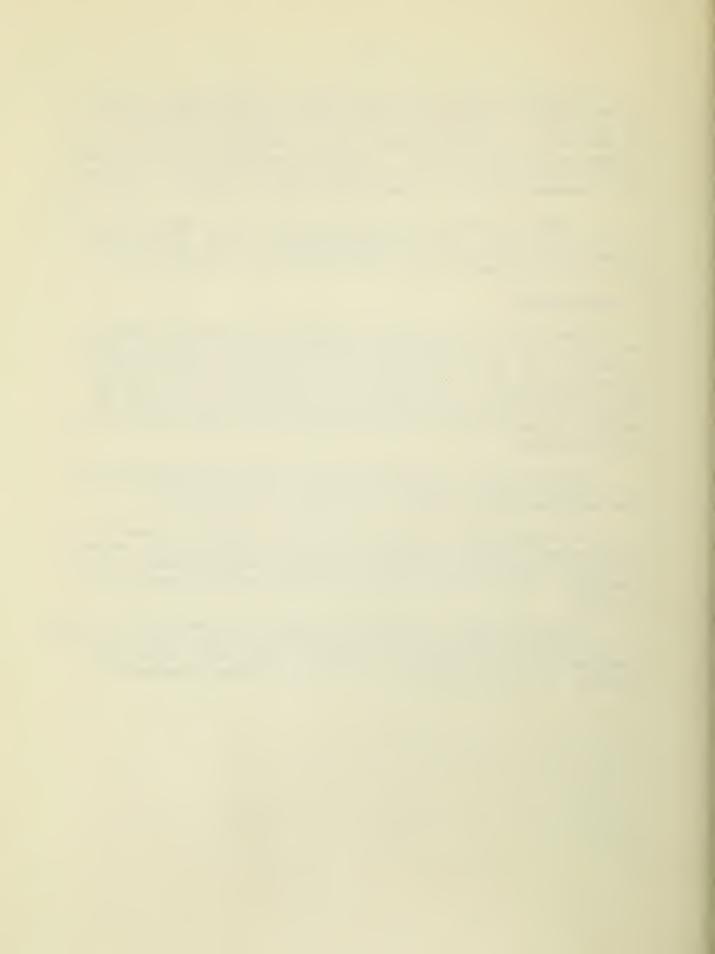
D. Other Events

During the time the Elliotts were in unit 7-3, correction officers moved the inmates to the baseball field behind the two and the six units. In general, the inmates cooperated, and there were no serious incidents reported during this period. At about 1:30 PM the State Police entered the institution and took over the task of maintaining a watch over the inmates in the field. No evidence was presented to this committee to suggest that any other inmate was involved in any way with Walter Elliott in this incident.

Correction officers carried no weapons inside the institution except for armed observers located at posts on top of the Hospital Building and the Receiving Building. These officers did not fire any shots.

Tear gas was shot into unit 7-3 in the early afternoon. When State Police entered the unit, they found Mr. Elliott and Mrs. Elliott seriously wounded. Mrs. Elliott was taken by ambulance to Norwood Hospital, where she later died. The institution was considered secured at approximately 4:30 PM.

The Medical Examiner's Certificate of Death for Walter Elliott indicated that the cause of death was suicide at 3:00 PM on July 31, 1972. An autopsy performed by Jacob Zalvan, M.D., revealed a "tight contact wound, left anterior chest with perforation of left lung and massive hemothorax."



INTERPRETATION OF THE FACTS

SURROUNDING THE INCIDENT OF JULY 31, 1972

The Committee has carefully reviewed all the testimony and other material presented to it and has arrived at the following conclusions:

1. Entrance of the weapons into the institution.

It is the conclusion of the Committee that the weapons and ammunition used in this incident were brought into the institution by Mrs. Katherine Elliott on the morning of July 31, 1972, and were handed over to Walter Elliott in the visiting room within minutes of his arrival there. It is the opinion of the Committee that Walter Elliott could not have brought the weapons into the visiting room on his person because of the shakedown he was given (and fully expected) at the main gate and because of the tightness of his trousers. There was no evidence to suggest that the guns were planted in the visiting room, nor was there any evidence to suggest that any other person -- inmate, employee, or visitor -- was involved in the incident in any way. Officer Albert Waitkevich who accompanied Mrs. Elliott in the ambulance to the Norwood Hospital reported that he saw tape marks across Mrs. Elliott's entire lower abdomen.

2. Motivation for the incident.

It is the conclusion of the Committee that the motive for this incident was suicide for both Mr. and Mrs. Elliott. No evidence was presented to the Committee to suggest that an escape attempt was on the minds of the Elliotts. In the visiting room, they had ample opportunity to take hostages and attempt to go out the front door, but they did not do so. Mrs. Elliott was dropped off at the institution by a taxi and there was no evidence that there was any help awaiting the Elliotts on the outside to complete an escape plan. Nor was there any evidence that any other inmate was involved in a possible escape plan that morning. Further, the deliberate, calm, cool behavior of the Elliotts on that morning, which was noted by virtually every eyewitness, indicated that they had a goal in mind and that they had pre-arranged plans to accomplish the goal. It is the opinion of the Committee that this goal was suicide for both individuals.

3. Security on the morning of July 31.

It is the conclusion of this Committee, based on the evidence presented to it, that existing security policies, procedures, and practices were adhered to on the morning of July 31. That is, it is the opinion of the Committee that no employee failed to carry out his responsibilities according to existing security practices on the morning of July 31. This is not to say, by any means, that security practices were adequate on the morning of July 31. The most glaring inadequacy was the absence of a metal detector.



4. Judgement of correctional administrators.

It is the conclusion of the Committee that the judgements and decisions made by correctional administrators concerning the events leading up to July 31 were reasonable ones under the circumstances existing at both Walpole and Norfolk. This includes the decision of the Acting Commissioner and her staff not to transfer the five men (including Walter Elliott) involved in the alleged escape plan from Norfolk to Walpole at that time, and the decision of Superintendent Bohlinger and his staff not to lock the five inmates up in the Norfolk Receiving Building, at that time. The Committee is satisfied that the bases of these decisions, which included conditions at Walpole and Norfolk that were cited above in this report, were solid.

RECOMMENDATIONS

The Committee has a number of recommendations to present. Some of these are specific and others are more general. In our later report we hope to expand considerably on our recommendations --- especially the more general ones. The recommendations include the following:

1. Metal Detector

The walk-through metal detector has already been installed. A second, portable metal detector should be considered to be used on inmates coming through the main gate to the visiting room and elsewhere.

2. Female Correction Officers

Three female correction officers are needed to search female visitors when required. The Committee does not suggest that all visitors be searched every time, but only when indicated.

3. Expansion of Visiting Room

The visiting room is totally inadequate. On Sundays, during the day, there is an average of 446 persons in the visiting room. This presents an unpleasant and uncomfortable environment for visits because of the crowding, as well as a serious security problem. Plans are under way to construct an addition to the visiting room. This project should be given top priority.

4. Increase in Staff

Increases in the number of visitors and civilian volunteers coming into the institution should be matched with a corresponding increase in staff. It should be stressed that the Committee strongly feels that family visits and the involvement of civilian volunteers in institutional programs are very important and should be encouraged.

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However, it is also important to ensure that these programs and visits are adequately covered.

The problem of inadequate staffing has been compounded recently by an increasing number of court trips and hospital watches (i.e., providing custodial coverage for inmates in civilian hospitals), which must be done by officers.

The Committee recommends that 25 additional correction officer positions be added at Norfolk. This number of officers will provide full-time coverage for five posts.

5. Improved Staff Training

Immediate attention should be directed to staff training at all levels. This is particularly crucial at this time when the correctional system is beginning to undergo some significant changes.

6. Procedures in Writing

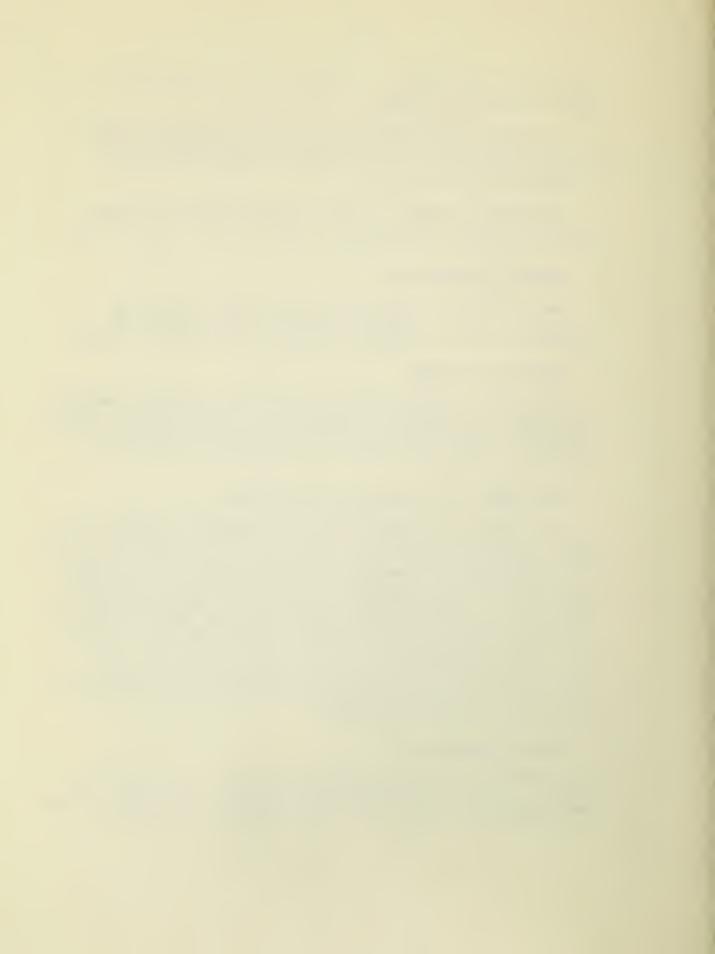
Institutional policies, rules and regulations, procedures and post orders should be in writing. At Norfolk there is an excellent beginning in this area. This should be pursued because it was evident to the Committee that there was confusion by staff members regarding some institutional procedures.

7. Improvements in the Classification Procedures

It was clear to the Committee that there has been a serious breakdown in the effective operation of the classification process. The very presence of Walter Elliott in an institution such as Norfolk testifies to this breakdown. The Committee is aware that serious overcrowding in the institutions has not left many alternatives open to the classification boards. The Department should press for the establishment of a Reception and Diagnostic Center. It should emphasize classification as an ongoing process, adding new staff and providing better training for new and existing staff. It is especially important, as we are on the threshold of implementation of Chapter 777 with all the new programs it includes, that classification become a viable and effective process so that appropriate inmates can be referred to the various correctional facilities and programs.

8. Security Management Team

The Department recently acquired the position of Chief Security Officer. A staff should immediately be assigned to this position so that security procedures in all institutions can be thoroughly reviewed and recommendations made to the Commissioner and Superintendents.



9. Adjustment Center

The Department should establish, outside the confines of any existing correctional institution, an adjustment center for those inmates who present chronic behavioral problems in the institutions. The adjustment center, with a capacity of about 50, should include a well-rounded, positive, treatment program with a strong research component. The facility should not be used for punishment. Decisions regarding transfer to such a facility should be made as part of the classification process.

10. Electricity in Wires on Walls

At present it is impossible to determine whether or not electricity is flowing through the wires on the walls without having the electrician climb up and check it out. Appropriate devices should be installed so that this can be determined at a glance.

11. Carefully Planned and Full Implementation of Chapter 777

The carefully planned and full implementation of the Correctional Reform Act (CH. 777) is critical at this point. The availability of new programs such as community facilities, furloughs, work release, education release, vocational release, etc., should go a long way in helping to reduce the tensions in the institutions. These programs offer significant incentives for inmates. They also represent important tools for officers inasmuch as they provide them with positive rewards which can be offered to inmates for appropriate behavior in institutions. Officers no longer will have to rely primarily on negative sanctions to help foster appropriate behavior among inmates.

Implementation of Chapter 777 will also help to ease the serious problem of overcrowding in the institutions. The Committee feels that this overcrowding is an important factor contributing to the relatively high level of tension in the institutions.

12. Morale and Communication

One of the most critical issues which emerged from our inquiry at Norfolk was the extremely low morale of the correction officers. The officers feel isolated, with respect to the inmates and with respect to the administration --- especially, the central office administration. The Committee sensed a kind of "twofold polarization process" going on whereby the tension between officers and inmates seems to be rising and, at the same time, the tension between officers and administration seems to be rising --- again, especially between officers and central office administration. They feel that the administration is much more concerned with the inmates than it is with the officers. They don't feel as though they are involved in decision-making processes.



They are confused on recent changes in policies and procedures. The Committee feels that this is a very serious situation and that steps must be taken immediately to deal with it.

Part of the morale problem seems to stem from generally poor communication among all correctional personnel throughout the system. The Committee fully realizes that the last several months has been a crisis-oriented period and that there has been little time available to establish effective communications. It is imperative, however, that steps be immediately taken to establish and maintain open channels of communication from the Commissioner down through the ranks and back to the Commissioner.

With the passage of Chapter 777, the correctional system in Massachusetts is on the threshold of a new era. It is crucial, particularly at this time, that all correctional personnel work together to effectively implement the programs possible under Chapter 777, and to achieve the goal of the successful reintegration of the offender back into community life.

With the development of mutual understanding and cooperation among all correctional workers, the prospects for the future, particularly with the passage of Chapter 777, could indeed be bright.

CONCLUDING COMMENT

The Committee wishes to point out that this is an interim report covering the happenings at MCI, Norfolk on July 31, 1972, when four people lost their lives at that institution and one additional person was seriously wounded. Due to the seriousness of the situation and the urgency for some fact finding, the Committee has only addressed itself to the main thrust of your request, namely to investigate the incidents and circumstances leading up to the tragic deaths at MCI, Norfolk. However, in establishing the facts regarding this incident, the Committee heard testimony on a much broader scope which indicates that a fuller explanation and report is necessary to close out your request in a manner that will not only set the Norfolk incident in its proper frame of reference but will pinpoint serious problems in the Norfolk institution applicable in large measure to other institutions mentioned in your second charge to the Committee. This second report will require some four to six weeks to complete at which time the Committee will present it to you for your perusal.

As a conclusion to this interim report the Committee would be remiss in its duty if it did not detail the cooperation received from many quarters. We found all personnel and inmates at the MCI, Norfolk both concerned and anxious to share with the Committee their facts regarding this incident and their concern for preventing a similar incident occurring in the future. We found the Superintendent, Deputy Superintendent, higher eschelon personnel in every division, Union



representatives, line personnel, inmates and inmate visitors most cooperative and even anxious to share their experiences with us. Special mention should go to Mrs. Ada Mulcahy and Miss Betty Ray of Walpole and Norfolk, respectively, for their assistance in the early stages of the transcript when both the machines were not operating well and the time element forced them to give extra time to the task. We are appreciative of the girls from the main office, Mrs. Doris Dorsey, Miss Arnetta Gibert, and Miss Carrie Lutz, who gave of their time and talent to expedite the transcribing of the minutes of our interviews. A particular thanks from the Chairman of this Committee to Mr. Fred Butterworth, Mr. Henry J. Mascarello, Major John M. Keeley of the Public Safety Department, and Mr. Francis J. Carney of the main office staff for their long hours listening to testimony and more hours spent reading the testimony, making notes and being prepared each day to evaluate what they had heard and read. Three of the Committee forfeited summer vacation periods to serve on the Committee; Mr. Mascarello took the necessary time away from his private agency job; and the Chairman asked to be relieved of his paid consultant job to serve. It should be further noted that all parties concerned on the Committee served without remuneration and the total expenses incurred by the Committee were less than fifty dollars (\$50.00) to complete the report. Finally, all the Committee members felt the time well spent in the interest of public safety, officer morale and, more importantly, placing the facts as this Committee saw them before you for your consideration.

Respectfully submitted,

John A. Gavin, Chairman

Fred Butterworth, Member

